

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017722

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2168 STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY Jackson
 b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN Kansas City Length of stay in lb 37 yrs
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hosp Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Jackson
 c. CITY OR TOWN Kansas City Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1015 Admiral Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Wilbur Middle LEE Last Raine
4. DATE OF DEATH Month 5 Day 1 Year 61

5. SEX male **6. COLOR OR RACE** white **7. Married** **Never Married**
Widowed **Divorced** **8. DATE OF BIRTH** 11-11-90 **9. AGE (last birthday)** 70

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard **10b. KIND OF BUSINESS OR INDUSTRY** Bombers Patrol **11. BIRTHPLACE** (City and state or country) Harpers, Kansas **12. CITIZEN OF WHAT COUNTRY** U.S.A

13. FATHER'S NAME Phillip Thomas Raine **13b. MOTHER'S MAIDEN NAME** Sarah Jane Day **NAME OF HUSBAND OR WIFE** Ruth Raine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) no **16. SOCIAL SECURITY NO.** no **17. INFORMATION** Address 200, mo.
Mrs. Ruth Raine: 1015 Admiral

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Congestive Heart Failure
 DUE TO (b) with Cardiac Dilatation
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO **20a. ACCIDENT** **SUICIDE** **HOMICIDE** **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK **NOT WHILE AT WORK** **20e. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ **20f. CITY, TOWN, OR LOCATION** _____ **COUNTY** _____ **STATE** _____

21. I attended the deceased from 4-30-61 to 5-1-61 and last saw him/her alive on 5-1-61
 Death occurred at 6:40a on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. Frank Ellis **22b. ADDRESS** 2400 Cherry City **22c. DATE SIGNED** 5/1/61

23. BURIAL, CREMATION, EMOVA (Specify) Burial **23b. DATE** 5-4-61 **23c. NAME OF CEMETERY OR CREMATORY** Memorial Park Cemetery Kansas City, Missouri **23d. LOCATION** (City, town, or county) _____ (State) _____

24. FUNERAL DIRECTOR Neilert Funeral Homes (S) L.C. Mo **ADDRESS** _____ **25. DATE RECD. BY LOCAL REG.** 5-2-61 **26. REGISTRAR'S SIGNATURE** Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Frank Ellis

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

B. E. Weibert

Licensed Embalmer No.

4075

P. O. Address

208, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.